ENTERS FOR MEDICARE & MEDICA	OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	155066	a. building B. wing	COMPLETED 08/10/2011

		B: WHIG				
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
EDOE:	WATER WOODS	1809 N MADISON AVE ANDERSON, IN46011				
EDGEW	ATER WOODS					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
K0000						
	A Life Sefety Code Description and	K0000		·		
	A Life Safety Code Recertification and	KUUUU				
	State Licensure Survey was conducted by					
	the Indiana State Department of Health in					
	accordance with 42 CFR 483.70(a).					
	G D (00/10/11					
	Survey Date: 08/10/11					
	Facility Number 000026					
	Facility Number: 000026 Provider Number: 155066					
	AIM Number: 100274820					
	Surveyor: Phillip Komsiski, Life Safety					
	Code Specialist					
	Code Specialist					
	At this Life Safety Code survey,					
	Edgewater Woods was found not in					
	compliance with Requirements for					
	Participation in Medicare/Medicaid, 42					
	CFR Subpart 483.70(a), Life Safety from					
	Fire and the 2000 edition of the National					
	Fire Protection Association (NFPA) 101,					
	\ ' '					
	Life Safety Code, (LSC), Chapter 19,					
	Existing Health Care Occupancies and					
	410 IAC 16.2.					
	This one story facility with a basement					
	1 * *					
	was determined to be of Type V (111)					
	construction and was fully sprinklered.					
	The facility has a fire alarm system with					
	smoke detection in the corridors and					
	spaces open to the corridors. The facility					
	has a capacity of 125 and had a census of					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

775121

Facility ID: 000026

PRINTED: 08/23/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICAT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION 01	(X3) DATE S COMPLI	ETED
		155066	B. WING			08/10/20	011
	ROVIDER OR SUPPLIER		1	809 N N	DDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN46011		
		TATEMENT OF DEPLOYED VOICE					(M2)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	1	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T	AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	74 at the time of	this survey.		ĺ			
		Robert Booher, Life Safety dical Surveyor on 08/12/11.					
	The facility was	found not in compliance					
	with the aforeme	ntioned regulatory					
	requirements as e	evidenced by the					
	following:						
K0017	Corridors are sepa	arated from use areas by					
SS=E	resistance rating. partitions are only passage of smoke buildings, walls pro ceiling. (Corridor of	with at least ½ hour fire In sprinklered buildings, required to resist the . In non-sprinklered operly extend above the walls may terminate at the gs where specifically					
	permitted by Code	. Charting and clerical					
		reas, dining rooms, and y be open to the corridor					
	under certain cond	litions specified in the Code.					
		separated from corridors valls if the gift shop is fully					
		.3.6.1, 19.3.6.2.1, 19.3.6.5					
		ation and interview, the	K001	7	The filing of this plan of		09/09/2011
	_	ensure 3 of 4 open use			correction does not constit an admission that the alleg		
	met an Exception	ated from the corridor, or			deficiency did in fact exist.	- 1	
	_	paces shall be permitted			This plan of correction is fi		
		n area and open to the			as evidence of the facility's	8	
		d the following criteria			desire to comply with the regulatory requirements ar	_{nd}	
	are met: (a) The	spaces are not used for			to continue to provide qual		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 775121

Facility ID:

000026

If continuation sheet

Page 2 of 16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING 01		COMPLETED	
		155066	B. WIN			08/10/2	011
		l	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIEF	₹	1809 N MADISON AVE				
EDGEW	ATER WOODS		ANDERSON, IN46011				
		CTATEMENT OF DEFICIENCIES		L	,		(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710	•		+	1710	care.		Ditte
	1	rooms, treatment rooms,			care.		
		as. (b) The corridors onto			Facility corridors are		
	1 -	s open in the same smoke			separated from use areas	by	
	1	e protected by an			walls constructed with at I	•	
	1	rvised automatic smoke			½ hour fire resistance rati		
	1	in accordance with				3	
	· ·	noke compartment in			Corrective action		
	which the space	is located is protected			accomplished for those		
	throughout by qu	uick-response sprinklers.			residents found to have		
	(c) The open spa	ice is protected by an			been affected:		
	electrically supervised automatic smoke detection system in accordance with						
					Smoke detectors will be inst		
	1	tire space is arranged and			in the following rooms. No comes were identified.	other	
		direct supervision by the			rooms were identified.		
		n a nurses' station or			Front entrance reception	on	
	1 *	d) The space does not		office			
		o required exits. This			Rehab dining room on	100	
		e could affect 2 residents			Hall	0.1.1-11	
	1				3. TV lounge room on 30	о нап	
	_	ng by the front Reception			The facility will install a fire		
	· ·	nts on 100 hall and 34			sentinel on the metal rolling	door	
		hall as well as visitors			that will release upon activat	tion of	
	and staff.				the fire alarm system. The f		
					requested a vendor bid for the	nis	
	Findings include	»:			work to be completed.		
					How the facility identified	other	
	Based on observ	ations on 08/10/11 during			residents having the poter		
	the tour between	11:15 a.m. and 3:30 p.m.			to be affected:	21 	
	with the Mainter	nance Supervisor,					
		equirement (c) of the Life			All residents residing in thes		
	_	apter 19.3.6.1 was not			areas have the potential to b		
	1 -	The sliding glass doors			affected. No other rooms we	ere	
		ront entrance Reception			identified.		
		self closing and were open			Regarding the kitchen wall		
		ance corridor. Also, the			opening to the dining room,	all	
	To the nont entra	mee corridor. Also, the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155066	B. WIN			08/10/2011
NAME OF I	PROVIDER OR SUPPLIER)		STREET AI	DDRESS, CITY, STATE, ZIP CODE	
NAME OF	I KO VIDEK OK SUFFLIER	X.			MADISON AVE	
EDGEW.	ATER WOODS			ANDERS	SON, IN46011	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	_	om on 100 hall is open to			residents who eat meals in the	ne
	the corridor and	does not have smoke			main dining room have the potential to be affected.	
	detector protection	on. Lastly, the TV lounge			potential to be allected.	
	room on 300 hall	l was open to the corridor			Systemic Changes the fac	cility
	and did not have	smoke detector			made:	
	protection. None	e of the rooms had direct				
	supervision by fa	acility staff from a			Future room modifications	
	1 ^ -	ffed area such as a nurses'			involving room openings to	the
	1	n interview on 08/10/11			patient corridors will include installation of an electrically	uie
		each observation with the			supervised smoke detector.	
	Maintenance Sur					
	1	ne aforementioned rooms			How the corrective action	will
	1	corridor without			be monitored:	
	1 -	the nurse's station and			<u>-</u> ,,	
	1 -	ed by automatic smoke			The Maintenance Director	
	detection.	ca by automatic smoke			monitor the installation of	
	detection.				smoke detectors. No other rooms were identified.	;
	3 1 10/6)				rooms were lucilliilea.	
	3.1-19(b)				The fire protection vendor	will
	Događ sa shasa	ation and intermi 41			inspect the metal rolling de	
		ation and interview, the			in dietary at least quarterly	l l
	1 .	provide 1 of 1 metal			,	
	"	ween the kitchen, a			The Quality Assurance	
	1	and the corridor to close			Committee (CQI Committee	' I I
	1	th the fire alarm system			will meet at least quarterly	to
		oke resistant barrier.			review any developments	
	1	actice could affect 6			identified concerning Life	
		ed in the main dining			Safety Code and make	
	room as well as v	visitors and staff.			recommendations for any	
					necessary action required	·
	Findings include	<i>:</i>			By what date the system	ic
					changes will be complete	
	Based on observa	ation on 07/14/11 at 1:40			changes will be complete	zu.
	p.m. with the Ma	aintenance Supervisor, the			September 9, 2011	
	1 ~	or in the kitchen wall was			55ptombor 0, 2011	
FORM CMS-2	2567(02-99) Previous Version		- 775121	Facility II	D: 000026 If continuation s	heet Page 4 of 16

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	A. BUILDING	01	COMP 08/10/2	LETED
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
EDGEW	ATER WOODS			MADISON AVE RSON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	to the corridor. Sexiting the dining open with doorst into their frames dining room is the corridor wall was protected with which does not rethe fire alarm systarea open to the interview on 07/the Maintenance acknowledged by Supervisor the reclose automatica	g room which was open ince the set of doors g room were propped ops and would not latch the wall around the terefore, considered to be. The kitchen opening the arolling metal door elease upon activation of stem leaving a hazardous corridor wall. Based on 14/11 at 1:45 p.m. with Supervisor, it was the Maintenance of the and would leave the otected.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066		(X2) MU A. BUIL		ot 01	(X3) DATE S COMPL	ETED	
		155066	B. WINC	·		08/10/2	011
	ROVIDER OR SUPPLIER			1809 N N	DDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN46011		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Γ'	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018 SS=E	than required enchexits, or hazardous doors, such as the solid-bonded core resisting fire for at sprinklered buildin resist the passage impediment to the are provided with a keeping the door of meeting 19.3.6.3.6. Roller latches are regulations in all h Based on observation facility failed to a 100 hall would ladeficient practice on 100 hall as well between 1:00 p.m. Maintenance Supleading into reside and 110 on 100 h into their frame. 08/10/11 concurr observation with Supervisor, it was	prohibited by CMS ealth care facilities. ation and interview, the ensure 2 of 28 doors on atch into their frame. This e could affect 32 residents ell as visitors and staff. ations on 08/10/11 a. and 1:35 p.m. with the pervisor, the doors lent room numbers 107 hall west did not latch Based on interview on ent with each	К0	018	The filing of this plan of correction does not constit an admission that the alleg deficiency did in fact exist. This plan of correction is fi as evidence of the facility's desire to comply with the regulatory requirements are to continue to provide qual care. The facility does have doo protecting corridor opening other than required enclos of vertical openings, exits, hazardous areas that are substantial doors, such as those constructed of 1 ¾ is solid-bonded core wood, capable of resisting fire for least 20 minutes. Corrective action	ged led s ad lity rs gs in ures or	09/09/2011
					accomplished for those		

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/10/2011
	ROVIDER OR SUPPLIER		1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE RSON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				residents found to have been affected:	
				Doors in resident rooms 107 110 were adjusted and latch into their frames and all doo the 100-Hall were re-checke latched into their frames.	ed rs on
				How the facility identifie other residents having t potential to be affected:	
				All residents residing on 100 have the potential to be affe All doors on the 100-Hall we re-checked to ensure they la into their frames. Any issue identified were immediately corrected.	cted. ere atched
				Systemic Changes the far made:	cility
				The Maintenance Directo re-checked all resident ro doors in the facility to ens they latched into their frar Any issues identified were immediately corrected.	om ure nes.
				How the corrective action be monitored:	will
				The Maintenance Director/Designee will check facility doors that require late into the frames for positive latching. Any issues identifi	ching

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066			(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/10/2011
	PROVIDER OR SUPPLIER		1809 N	ADDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0029 SS=E	fire-rated doors) of extinguishing system and/or 19.3.5.4 properties and/or 19.3.5.4 properties with a proved extinguishing system are separated from resisting partitions self-closing and not protective plates the from the bottom of 19.3.2.1 1. Based on obsetthe facility failed rolling doors sephazardous area, for close automatical fire alarm system resistant barrier.	d construction (with 3/4 hour ran approved automatic fire em in accordance with 8.4.1 otects hazardous areas. d automatic fire em option is used, the areas nother spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches the door are permitted. ervation and interview, to ensure 1 of 1 metal arating the kitchen, a from the corridor would around the corridor would around the corridor would the to maintain a smoke. This deficient practice sidents observed in the	K0029	be corrected following these checks. The Maintenance Director/Designee will conduthese checks at least month. The Quality Assurance Committee (CQI Committe will meet at least quarterly review any developments identified concerning Life Safety Code and make recommendations for any necessary action required. By what date the system changes will be completed. September 9, 2011 The filing of this plan of correction does not constitute and admission that the alled deficiency did in fact exist. This plan of correction is fast evidence of the facility's desire to comply with the regulatory requirements at to continue to provide quarter.	ee) to ic ed: 09/09/2011 tute ged illed s nd

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	A. BUILDING 01 COMPLET		ETED		
		155066	B. WIN			08/10/2	011	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	Į		
NAME OF P	PROVIDER OR SUPPLIE	₹		1	MADISON AVE			
	ATER WOODS			1	SON, IN46011			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION	
TAG	,		-	TAG	DEFICIENCY)		DATE	
	_	m as well as visitors and			care.			
	staff.				The facility does have			
					The facility does have one-hour fire rated			
	Findings include	: :			construction and an appre	havo		
					automatic fire extinguishing			
	Based on observ	ation on 08/10/11 at			system.	''9		
	11:40 a.m. with	the Maintenance			-,			
	Supervisor, the 1	netal rolling door in the			Corrective action			
	-	all was open to the dining			accomplished for those			
room which was open to the corridor and				residents found to have				
inspected annually, but did not release				been affected:				
	-	of the fire alarm system						
	_	ous area open to the			The facility will install a fire			
	_	ridor. Based on interview			sentinel on the metal rolling that will release upon activa			
	•	1:45 a.m. with the			the fire alarm system. The			
	Maintenance Su				requested a vendor bid for t			
		y the Maintenance			work to be completed.			
	_							
	-	olling metal door does not			Self-closing door devices wi installed on the 10 doors	II be		
		ally upon activation of the			referenced in the 2567.			
		n and would leave the			10.0.0.000 0.0 2007.			
		otected as well as the			How the facility identifie	d		
	corridor.				other residents having t			
					potential to be affected:			
	3.1-19(b)							
					All residents who eat meals			
		·						
	leading to hazar	dous areas such as			•	io be		
	kitchens, soiled	linen rooms or rooms						
	with combustible	e items were provided			Systemic Changes the fa	cility		
	with self closing devices which would				made:			
	cause the door to	automatically close and						
		or frame. This deficient						
	practice affects 3	3 residents observed in the			re-checked all facility doo	rs		
	the facility failed leading to hazar kitchens, soiled with combustible with self closing cause the door to latch into the do	linen rooms or rooms e items were provided devices which would o automatically close and or frame. This deficient			All residents who eat meals main dining room, who utiliz service corridor and reside of 300-Hall have the potential affected. Systemic Changes the fa	e the on to be cility		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155066	B. WIN	IG		08/10/20	J11
NAME OF	PROVIDER OR SUPPLIEI	R	-	STREET A	DDRESS, CITY, STATE, ZIP CODE	-	
					MADISON AVE		
EDGEW	ATER WOODS			ANDER	SON, IN46011		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	\			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	m, 2 residents observed			leading to hazardous area		
	on the Service co	orridor and 8 residents on			containing combustible ite		
	300 hall, as well	as visitors and staff.			No additional doors requir	ing	
					self-closing devices were		
	Findings include	:			identified. Self-closing do		
					devices will be installed in rooms converted in location	· · ·	
	Based on observ	ration on 08/10/11 during			that lead to hazardous are	_	
		12:31 p.m. and 3:00 p.m.			or contain combustible ite		
		nance Supervisor, the			J. Johnson Johnson Ito		
	following doors leading to a hazardous area were not provided with a door				How the corrective action	will	
					be monitored:		
	closing device:	ovided with a door					
	1	d and door landing into			The fire protection vendor	will	
	a. The south and east door leading into				inspect the metal rolling d	oor	
	the kitchen.	1 21 4			in dietary at least quarterly	y.	
	b. The Biohazai						
		on Service corridor			The Maintenance		
		supply room with fifty			Director/Designee will mo		
		on Service corridor			rooms requiring self-closir	- 1	
		nen room with soiled linen			door devices at least quar and any issues identified	· · ·	
	1	hirty gallon plastic			be corrected.	WIII	
	containers on Se	ervice corridor			be corrected.		
	e. The Nursing	supply room with five			The Quality Assurance		
	cardboard boxes	on Service corridor			Committee (CQI Committee	ee)	
	f. The storage re	oom with four cardboard			will meet at least quarterly	, I	
	boxes on Service	e corridor			review any developments		
	g. The Wheel cl	hair room with twenty			identified concerning Life		
	~	ooxes on Service corridor			Safety Code and make		
		supply room with twenty			recommendations for any		
	1	on Service corridor			necessary action required	.	
		torage room with twenty					
		oxes on 300 hall			By what date the system		
		office storage room with			changes will be complete	ed:	
	1 "	•					
	1	board boxes on 300 hall			September 9, 2011		
	Based on intervi	ew on 08/10/11					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066			(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/10/2011
	ROVIDER OR SUPPLIER		STREET 1809 N	ADDRESS, CITY, STATE, ZIP CODE N MADISON AVE RSON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0062 SS=E	Maintenance Supthe aforemention hazardous area rowith a self closing 3.1-19(b) Required automate continuously main condition and are periodically. 19.25, 9.7.5 Based on observation facility failed to a sprinkler heads the which had paint of NFPA 25, 1998 of any sprinkler shapping particle could afforbe improper oriely practice could afforbe improper oriely practice could afforbe improper oriely practice and as well as staff and Findings include. Based on observating the tour between	entions on 08/10/11 during 11:15 a.m. and 3:30 p.m.	K0062	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is fast evidence of the facility's desire to comply with the regulatory requirements at to continue to provide quactare. Required automatic sprink systems are continuously maintained in reliable operating condition and arinspected and tested periodically. Corrective action	ged illed s nd lity
	the following spr	rinkler heads had paint on		accomplished for those	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155066	A. BUILDING 01		08/10/2011
133000	B. WING		00/10/2011
NAME OF PROVIDER OR SUPPLIER		ESS, CITY, STATE, ZIP CODE	
EDGEWATER WOODS	1809 N MAD ANDERSON,		
		, IIN+OO I I	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES	ID (F	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE
	+ + + -	sidents found to have	DATE
the fusible link:		een affected:	
a. One sprinkler head above the metal		Jon angoleu.	
curtain in the Main dining room	Th	ne 13 sprinkler heads identi	fied
b. One sprinkler head above the clock in		the 2567 will be replaced.	
the Main dining room			
c. One sprinkler head in room 113 south		ow the facility identified	l l
end of wall	l l	her residents having th	e
d. One sprinkler head in room 115 south	po	otential to be affected:	
end of wall		I rooidonto vibo oot in the	
e. One sprinkler head in room 118 south		I residents who eat in the	†
end of wall		ning room, reside on 00-Hall and 300-Hall hav	_
f. Two sprinkler heads in room 309	l l	e potential to be affected	
g. Two sprinkler heads in room 310		o potential to be allected	"
h. Two sprinkler heads in room 312	sy	ystemic Changes the fac	ility
i. One sprinkler head in Social services	1 1 1	ade:	-
room on 100 hall			
j. The Snoezelen room at the end of 300	1	ne remaining sprinkler he	
hall has one sprinkler head on the south	1	the facility will be inspec	ted
side of the room.	1 .	the Maintenance	
Based on interview on 08/10/11	1	upervisor and the fire	
concurrent with each observation with the	1 '	otection vendor. A bid w	/III
Maintenance Supervisor, it was confirmed	l l	e obtained from the fire	
the sprinkler heads located in the	1 '	otection vendor for the	or
aforementioned rooms had paint on the	1 .	placement of any sprinkle eads identified with paint	l l
fusible link.		e fusible link.	
Tusivic IIIIk.		o igololo iiilit.	
2.1.10(b)	Sr	orinkler heads will be	
3.1-19(b)	1 '	otected while completing	,
	1 '	eiling/wall painting or	
		xturing.	
		ow the corrective action	will
	be	e monitored:	
	_{Th}	ne Maintenance	
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 77		000026 If continuation sh	leet Page 12 of 16

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/10/2011
	ROVIDER OR SUPPLIER		STREET A 1809 N	DDRESS, CITY, STATE, ZIP CODE MADISON AVE SON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Director/Designee will ins sprinkler heads semi-ann and any issues identified be corrected.	ually
				The Quality Assurance Committee (CQI Committ will meet at least quarterly review any developments identified concerning Life Safety Code and make recommendations for any necessary action required	y to
				By what date the system changes will be complet	
				Due to the volume of sprin heads that require inspect and the potential for addit sprinkler head replaceme the facility requests an extension of 45 days to complete this process. Facility staff will be inserved on the facility's fire prever and fire watch policies.	tion ional nts, iced
K0069		are protected in accordance .2.6, NFPA 96		October 24, 2011	
SS=E	1. Based on obsethe facility failed of 1 exhaust hoo cooking equipmed requirements of 1	ervation and interview, I to install and maintain 1 ds used for commercial ent in accordance with the NFPA 96, 3-1 which ease filters, baffles, or	K0069	The filing of this plan of correction does not const an admission that the alle deficiency did in fact exist This plan of correction is as evidence of the facility	ged filed

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01		01	COMPLETED		
155066			B. WIN			08/10/2011	
NAME OF I			!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIER				1809 N	MADISON AVE		
EDGEWATER WOODS				ANDER	RSON, IN46011		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·	DATE	
	1 11 0	rease removal devices for			desire to comply with the	nd	
		rcial cooking equipment			regulatory requirements a to continue to provide qua		
		d. Listed grease filters			care.	illey	
	shall be tested in	accordance with UL			cale.		
		ters for Exhaust Ducts.			Cooking facilities are		
	Mesh filters shal	l not be used. This			protected in accordance v	vith	
	deficient practice	e could affect 2 residents			NFPA.		
	observed in the I	Dining room, as well as					
	visitors and staff				Corrective action		
					accomplished for those		
	Findings include	:			residents found to have		
	i manigs merade.				been affected:		
	Based on observation on 08/10/11 at 02:05 p.m. with the Maintenance Supervisor, the kitchen range hood system had mesh type filters instead of baffle type filters. Based on interview on 08/10/11 at						
				The kitchen range hood mesh filter will be replaced with a listed grease filter in accordance with			
					UL 1046.	vitii	
					02 10 10.		
					be		
	02:07 p.m. with the Maintenance			relocated to the north wall of the			
	Supervisor it was acknowledged the filters				kitchen and a placard will po	sted	
	in use were mesh filters.				above the extinguisher.		
	21.122				How the facility identified	d	
	3.1-19(b)				other residents having the		
					potential to be affected:		
		ervation and interview,			•		
	the facility failed to install and maintain 1				All residents who eat in th	e	
of 1 cooking facilities in accordance with				dining room have the pote	ential		
	the requirements of NFPA 96, 7-2.1.1 which requires a placard identifying the use of the extinguisher as a secondary backup means to the automatic fire				to be affected.		
					Systemic Changes the fac	cility	
					made:		
	suppression syste	em shall be conspicuously			The kitchen range head man	,	
	1	portable fire extinguisher			The kitchen range hood mes filter will be replaced with a l		
	_	ea. Additionally, NFPA			grease filter in accordance w		
	1	, 2-3.2 requires fire			UL 1046.		
	1 -0, 1000 Eartion	, = -: - : • q a • > 111 •					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED	
	155066 B. WING				08/10/2011		
					ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF PROVIDER OR SUPPLIER				MADISON AVE			
EDGEWATER WOODS					RSON, IN46011		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)	DATE	
		ovided for the protection			The K class extinguisher will	he	
	0 11	ances use combustible		relocated to the north wall of the kitchen and a placard will posted			
		vegetable or animal oils					
	· ·	listed and labeled for			above the extinguisher.		
	Class K fires. N	FPA 10, 2-3.2.1 requires					
	a placard shall be	e conspicuously placed			How the corrective actio	n	
	near the extingui	sher which states the fire			will be monitored:		
	protection system	n shall be activated prior			The fire protection was de-		
	to using the fire	extinguisher. Since the			The fire protection vendor inspect the kitchen range	WIII	
	fixed fire extingu	iishing system will			hood at least semi-annual	ly to	
	automatically shut off the fuel source to				ensure that hood contains	· I	
	the cooking appliance, it is preferential to				listed grease filter in	, u	
	activate the fixed system before using a				accordance with UL 1046		
		-			The Maintenance Supervi	sor	
	portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect 2 residents, observed in the Dining room as well as visitors and staff. Findings include: Based on observation on 08/10/11 at 2:08 p.m. with the Maintenance Supervisor, there were two portable fire extinguishers				will monitor the kitchen rai		
				hood at least semi-annually and any issues identified will			
					be corrected.		
					The fire protection vendor	will	
					inspect the K class		
					extinguisher at least annu	ally.	
					The Maintenance Supervisor/Designee will		
					monitor the K class		
		One, an ABC type, was			extinguisher at least mont	hlv	
		aced on the north wall of			and any issues identified	· 1	
		he second extinguisher, a			be corrected.		
		conspicuously located			-		
	_	card. Based on interview			The Quality Assurance		
	on 08/10/11 at 02	2:10 p.m. with the			Committee (CQI Committee	ee)	
	Maintenance Sup	pervisor, it was			will meet at least quarterly	to	
	acknowledged th	e K class portable fire			review any developments		
	extinguisher was	not conspicuously			identified concerning Life		
	located and lacke				Safety Code and make		
		-			recommendations for any		
					!		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155066	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 08/10/2011
NAME OF PROVIDER OR SUPPLIER				1	DDRESS, CITY, STATE, ZIP CODE MADISON AVE	
EDGEWATER WOODS					SON, IN46011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)				necessary action required	
					By what date the system changes will be complete	
					September 9, 2011	